THOMAS CHITTENDEN
HEALTH CENTER

PATIENT REGISTRATION AND CONSENT FORM

PATIENT INFORMATION

First Name _____ Last Name _____ MI____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip Code _____

Primary phone _____ ○ Mobile ○ Landline Secondary phone _____ ○ Mobile ○ Landline

Email address _____

Guardian Name (if under age 18): _____ Guardian DOB: _____

Guardian address (if different than patient) _____

Legal sex _____

*While TCHC recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Marital Status _____
Gender Identity _____
Preferred Pronoun _____

EMERGENCY CONTACT

Name _____ Phone # _____ Relationship _____

Due to recent changes in Federal regulations we are required to collect the following information for all Thomas Chittenden Health Center patients.

Race: ☐ Caucasian/White ☐ Asian-American ☐ African-American ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ Other _____ ☐ Decline to answer

Preferred Language: ☐ English ☐ Other (please specify) _____ ☐ Decline to answer

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer

CONSENT

Consent to Use or Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I consent to allow Thomas Chittenden Health Center to use or disclose my protected health information for treatment, payment and health care operations

1. **Treatment** means the provision, coordination or management of health care and related services by one or more health care providers.
2. **Payment** means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provisions of health care.
3. **Health care operations** means conducting quality assessment and improvement of activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Thomas Chittenden Health Center.

I consent to allow Thomas Chittenden Health Center to access and share my protected health information for treatment activities of another health care provider.

I consent to allow Thomas Chittenden Health Center to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Thomas Chittenden Health Center to access and share my protected health information to another covered entity for health care operations activities, provided that Thomas Chittenden Health Center and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment or health care operations or for the purpose of health care fraud and abuse detection or compliance.

I consent to the access and sharing of my prescription medical information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health benefits program to Thomas Chittenden Health Center for the purpose of my treatment.

AUTHORIZATION

I acknowledge that this consent may be revoked by me at any time, except to the extent that Thomas Chittenden Health Center has already acted in reliance on it. I certify that the information on the previous page is true and correct. I will notify Thomas Chittenden Health Center of any changes in my living or insurance status. I acknowledge I received a copy of Thomas Chittenden's Notice of Privacy Practices and Billing Policy Agreement.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

Thank you for your cooperation in collection of this valuable data.

586 Oak Hill Rd, Williston, VT 05495
Phone (802)878-8131 Fax (802) 879-6853

THOMAS CHITTENDEN
HEALTH CENTER

CONSENT TO DISCLOSE HEALTH INFORMATION

I, _____ DOB _____
(Name of **PATIENT** whose information is being requested)

Authorize _____
(Name and address of person / agency **SENDING** information)

To disclose to: _____
(Name and address of person / agency **RECEIVING** information)

The **PURPOSE** of this disclosure is: _____

PLEASE CHECK ALL INFORMATION YOU WOULD LIKE TO HAVE SHARED:

☐ Entire Medical Health Record **Please specify date range from _____ to _____**

OR

☐ Thomas Chittenden progress notes/labs/EKGs/xrays

☐ Thomas Chittenden mental health records ☐ Thomas Chittenden substance abuse records

☐ Outside records (i.e. consults from specialists, imaging, labs, emergency room, hospital discharge, etc.)

☐ Outside mental health records

☐ Immunization record ☐ Other (please specify)_____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

_____ _____
PRINT NAME **RELATIONSHIP TO PATIENT**

You are authorizing Thomas Chittenden Health Center to disclose records in the following formats: verbal, written, electronic. This consent will expire one year from date signed. Transfer of records to another doctor office provided at no charge. Records provided to patient at cost of .50 cents a page.

Thomas Chittenden Health Center, 586 Oak Hill Rd, Williston, VT 05495
Phone (802) 878-8131 Fax (802) 879-6853

Privacy Policy
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Practice Administrator at 802-878-8131.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A provider treating you for an injury asks another provider about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: 7/25/2019
- Privacy Official: Cheryl McCaffrey, Practice Administrator, cheryl.mccaffrey@tchconline.com, 802-878-8131
- We will never market or sell any private information for any reason.
- We will never share any substance abuse or psychotherapy treatment records without your written permission.

THOMAS CHITTENDEN
HEALTH CENTER

PAYMENT POLICY

In order for Thomas Chittenden Health Center to successfully bill for the medical services rendered to you, we must rely on you to provide us with complete and accurate information. In order to assist us, for every appointment, please arrive 5 minutes early and be prepared to:

- Confirm/update your current address, telephone number and payment information;
- Make payment for the amount due at time of service according to this payment policy;
- If you have medical insurance, notify the receptionist of any insurance changes, provide all of your current insurance card(s) and properly identify each insurance plan as primary, secondary or tertiary;
- Inform us if your visit is for an injury that should be covered by workman's compensation or accident insurance;
- Bring your driver's license or photo identification.

Payment due at time of service:

All patients are expected to pay their co-pay on the day services are rendered or contact our billing office staff to make financial arrangements. All co-insurance and deductible amounts are due within 30 days after insurance payment is received. Payment may be made by cash, check, credit card or debit card.

- If you do not have medical insurance you are expected to pay in full for services rendered. A 30% discount will be applied if you have no insurance and pay at the time of service. If you do not pay at the time of service a payment plan must be arranged at the time of service.
- If you have medical insurance coverage by a plan with which **we have a contract** you are expected to pay your co-pay on the day services are rendered. If you **do not pay** your co-pay at the time of service and we have to send you a bill, an additional $10.00 fee may be added to your account to cover our costs.
- If you have medical insurance coverage by a plan with which **we do not have a contract** you are responsible to pay in full for services rendered. We will bill your insurance as a courtesy. If both you and your insurance plan pay for your services, we will refund your payment by check.

Thomas Chittenden Health Center currently has **contracts with the following insurance plans:**

Aetna (w/First Health Logo)	Aetna Open Access Select	Aetna PPO	Aetna POS2
BCBS of Vermont	Beechstreet Network	CBA/EBPA	Cigna
Coventry/First Health Network	UVM Medical Center	Medicare	MVP
Vermont Medical/Green Mtn Care	Tricare for Life	United Healthcare	
	***(NOT Aetna HMO or Aetna Tricare)**		

Outstanding balances:

Patients are expected to pay for services rendered according to this payment policy or contact our billing office staff to make financial arrangements. If we do not receive payment of your statement balance or a phone call to set up a payment plan within 30 days, your account will be considered past due and our staff will proceed with collection efforts. Please review your statement carefully and contact our billing office immediately if you have a question or think that you received the statement in error. **If your account is past due, please contact our billing office staff to discuss your account and make financial arrangements. We are here to help you.**

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Insurance claims:

We will submit your insurance claims for you if you provide us with complete and accurate information. In order for us to successfully submit your claims you must:

- Notify us immediately of all insurance changes;
- Present all of your current insurance cards **at every appointment;**
- Properly identify each insurance plan as primary, secondary or tertiary.

If you have an insurance plan with which **we do not have a contract**, you are expected to pay in full for services rendered. We will submit your insurance claims for you as a courtesy, however you are ultimately responsible for payment for services rendered. If you and your insurance plan both pay for your services, we will refund your payment by check.

Non-covered services:

Your insurance plan may not cover all medical services and may determine some services to be "not medically necessary". When your insurance plan makes this determination and allows us to bill you, you will be responsible for payment for the non-covered services.

Knowing your insurance benefits coverage is your responsibility. Please read your insurance plan materials carefully and contact your insurance company with questions so you are not surprised.

Coordination of benefits:

If your insurance company denies your claim(s) due to coordination of benefits, you will be responsible for payment of the remaining balance for services rendered. If you receive a statement from Thomas Chittenden Health Center stating a Coordination of Benefits issue you must call your insurance company immediately to straighten out your account with them and ask them to re-process your claim.

Workman's compensation or accidents:

If your visit is for an injury and should be covered by workman's compensation or accident insurance you must inform our staff when you schedule your appointment and complete the required forms when you check in. If you do not provide us with all the necessary information you will be responsible for payment for services rendered.

Custodial parent:

By law, if you are a custodial parent, you are responsible for your child's medical bills, even if you are not the carrier of your child's insurance policy.

Missed appointments:

We reserve the right to charge you for a missed appointment. If you are unable to attend a scheduled appointment you must call in advance to cancel. Insurance does not pay for missed appointments.

Lab services:

While we perform many laboratory services here at Thomas Chittenden Health Center, some tests ordered by our providers are performed at outside laboratories such as UVM Medical Center. You or your insurance company will receive a separate bill from an outside laboratory for those services.